handled in some instances. In other cases, a request that the provider serve as an intermediary, or a personal letter to the beneficiary, using a plain envelope, may be appropriate. Whatever approach is chosen, contractors must observe the intent, as well as the letter, of the Privacy Act.

3. EOB Format

The form design of the EOB is not specifically prescribed. Contractors shall design the form to fit their individual equipment and system needs. Prior to printing, however, the form must be approved by *TMA*. The following are required contents of the EOB:

a. Contractor Identification

The name or logo of the contractor and the region specific TRICARE logo must be present on the front of the EOB, even though it appears on a detachable check.

b. Form Title

"EXPLANATION OF BENEFITS" shall appear in a prominent place near the top of the EOB form in boldfaced type at least as large as the organization logo or name of the contractor, and in a type size and style which will make it clearly visible.

c. Form Subheadings

The subheadings "THIS IS A STATEMENT OF THE ACTION TAKEN ON YOUR CHAMPUS CLAIM," and "KEEP THIS NOTICE FOR YOUR RECORDS," shall also appear near the top of the form in a **boldfaced** type slightly smaller than the title of the form.

d. Data Required on Front of EOB Form

Provisions shall be made on the front of the form for inclusion of the following elements:

(1) The Internal Control Number (ICN)

(2) The Date the EOB is prepared (Run Date)

(3) Check Number

(4) The contractor's address and telephone number. The contractor's telephone number for the state or locality of the beneficiary or provider may be computer-printed.

(5) Sponsor's Social Security Number

(6) Beneficiary's Name and Sponsor's Name

The sponsor's last name and first name or initial, and the beneficiary/patient's **full first name** must be shown on the EOB.

(7) Payee's Name and Address

This space is used when payment is made to someone other than the beneficiary (parent/legal guardian of minor or incompetent); e.g., the provider, administrator of an estate or a Medicaid agency. The full name of the payee must be used, if available.

(8) Procedure Code and a short description of services. (Not required for claims paid under the *TRICARE* DRG-based payment system.)

(9) Date of Service or From - To Dates for combined services.

(10) Number of Services

Enter number of services provided when services are combined. (Not required for claims paid under the *TRICARE* DRG-based payment system.)

(11) Name of Provider of Service

Since prescription drugs are paid as billed, you may use "your pharmacy" for nonassigned prescription drug claims instead of developing for the name and address of each provider. In addition, "Your Provider" or "Your Supplier" may be used when **all** of the following conditions are met:

(a) A valid name/number cannot be assigned from the information at hand.

(b) The claim is totally denied

(c) The claim is non assigned

(12) Amount Billed

Enter amount billed by provider

(13) Amount Allowed

Enter amount allowed by *TRICARE*. For claims paid under the *TRICARE* DRG-based payment system, this will be a total amount for the entire claim and need not relate to individual line items. If, under a program approved by the Director, *TMA*, a provider has agreed to discount his or her normal billed charges below the profiled amounts, the amount allowed may not be more than the negotiated or discounted charges.

(14) *Payment Reduction Amount*

If applicable, enter the amount of the payment reduction as provided in the TRICARE/CHAMPUS Policy Manual, Chapter 13, Section 24.1.

(15) *Reduction Days*

If applicable enter the number of days subject to the payment reduction as provided in the TRICARE/CHAMPUS Policy Manual, Chapter 13, Section 24.1.

(16) Amount Paid by Beneficiary to Provider

Enter the amount, if any, paid by beneficiary to provider on participating claims.

(17) *Amount Allowed by Other Insurance*

If applicable enter the amount allowed by the other health insurance (OHI). See the TRICARE/CHAMPUS Policy Manual, Chapter 13, Section 24.1.

(18) Paid by other Insurance

Enter amount paid by other insurance (if applicable)

(19) Total Payment

Enter total amount paid on the claim

(20) Amount Accrued Toward Deductible Amount

Enter the amount of the individual deductible which has been satisfied for the fiscal year, including the amount applied on the current claim, and the amount of the family deductible which has been satisfied for the fiscal year.

(21) Amount Deductible this Claim

Enter the amount of the deductible satisfied by the current claim.

(22) Remarks/Action Section

(a) Enter reasons for disallowance or reduction in this space. (If codes are used, the corresponding messages must appear on the EOB.)

(b) When appropriate, enter the following: "Our records show XX days of inpatient mental health services have been used in calendar year XXXX." (If a contractor finds it more cost effective to send a separate letter or notice showing inpatient mental health days used, a copy of the proposed letter shall be sent to the *Operations Directorate, TMA*, for review and approval.)

(c) The "uniform" messages listed below are to be used by all contractors. Contractors may add wording to expand the basic explanation if the data system permits longer messages. Similarly, abbreviated words may be used if the system cannot handle the message length. Contractors are authorized to add new messages which pertain to their "in-system" processing requirements. These will be submitted to the *TMA*, Contracting Officer's Representative for approval. New messages for "out-of-system" processing may be submitted for approval, but not used prior to approval.

EOB Messages	
1	Nonavailability Statement not received
2	Authorization not on file; contact your HBA
3	Requested information not received.
4	Requested other insurance information not received.
5	Approval for such therapy not received.
6	Treatment summary not received.

EOB Messages (Continued)	
7	Claim requires drug name, strength and quantity.
8	Provider not TRICARE-authorized for this service.
9	Surgical assistant not authorized.
10	This ambulance service not covered.
11	Service requires physician referral.
12	Medical need not shown - court ordered care.
13	Medical need not documented.
14	Patient not eligible at time of service.
15	Patient eligible for Medicare.
16	Patient not eligible.
17	Family member status information not received.
18	Charge denied; this service must be submitted by the provider of care.
19	Services paid in full by other insurance.
20	This charge included in a paid service.
21	Included in maternity allowance.
22	More than allowable amount.
23	Service included in surgical allowance.
24	Anesthetic by attending physician in surgical allowance.
25	Psychiatric limits exceeded.
26	Physical therapy limit exceeded.
27	Speech therapy limit exceeded.
28	Maximum allowed for ambulance service paid.
29	Authorized service limits exceeded.
30	Charges exceed monthly maximum.
31	Service filed after time limit.
32	Services covered by Workers Compensation.
33	Duplicate of service previously claimed.
34	Nonprescription drug.

EOB Messages (Continued)	
35	Noncovered diagnosis.
36	Obesity not a covered diagnosis.
37	Noncovered services.
38	Routine physical not covered.
39	Routine immunization not covered.
40	Routine foot care not covered.
41	Orthopedic shoes not covered.
42	Routine test/lab/x-ray not covered.
43	Reserved
44	Noncovered routine eye examination.
45	Eye glasses/lenses not covered.
46	Eye refraction not covered.
47	Foot supports/orthotics not covered.
48	Chiropractic services not covered.
49	Personal comfort item not covered.
50	Domiciliary/custodial care not covered.
51	Sponsor not on DEERS.
52	Patient not eligible on DEERS.
53	
54	ID Card or eligibility expired on DEERS - see back.
55	Requested 3rd party info not received.
56	Charge covered by Residential Treatment Center payment.
57	Charge reduced for therapeutic absence exceeding 3 days.
58	Unauthorized therapeutic absence.
59	Requested third party liability information (DD Form 2527) not received.
60	Home Health Care Authorization not on file.
61	Personal Injury Insurance Payment Information Required.

EOB Messages (Continued)	
62	Insufficient information received.
63	Charges included in ambulance base rate.
64	Payment determined under DRG-based payment system; amount allowed is payment in full. DRG reclassification requests must be made within 60-days of payment.
65	These services must be billed separately.
66	DRG-based payments cannot be made for interim bills.
67	Outlier payments denied due to loss of beneficiary eligibility.
68	Incomplete/inaccurate claim cannot be paid under DRG-based payment system.
69	Not an authorized Partnership provider.
70	No patient liability; cost-shares and deductibles not applicable to Internal Partnership Program.
71	CHAMPVA beneficiaries are not eligible for Partnership Program.
72	Facility where services rendered not military facility.
73	Catastrophic cap reached, cost-shares and deductibles no longer apply.
74	Necessity for MRI not documented, paid as CT scan.
75	Charge reduced to established visit.
76	Claim has been split for processing.
77	No separate payment is allowed for incidental procedures.
78	No authorization on file.
79	Services or supplies are not authorized under the Program for Persons with Disabilities.
80	Interim DRG billing submitted out of order.
81	Interim DRG bill outside of dollar parameter.
82	Requirements for medical emergency not met - Nonavailability Statement required.
83	$____.__ has been applied toward the catastrophic cap of $1,000.00.
84	$____.__ has been applied toward the catastrophic cap of $7,500.00.
85	Catastrophic cap met with this claim. Cost-share/deductible reduced accordingly.

EOB Messages (Continued)	
86	Charges exceed daily maximum.
87	Payment amount determined under inpatient mental health per diem payment system and is payment in full.
88	Incomplete/Inaccurate claim cannot be paid under TRICARE inpatient mental health per diem payment system.
89	Patient ineligible for CHAMPVA. Contact CHAMPVA Center, Post Office Box 650244, Denver, CO 80206-9024.
90	Rehab limits reached. Submit detox services separately.
91	Outlier payments denied due to exceeding the 60-day limit.
92	This service allowed at 50% when performed in conjunction with anesthesia.
93	Payment reduced to negotiated rate(s).
94	Partnership claim denied; agreement has expired.
95	Payment denied for service(s) not included in Partnership agreement; beneficiary not liable - provider should contact MTF.
96	Providers will not collect additional cost-shares for increases in RTC rates, as a result of rebasing.
97	This service is included in the DRG-based payment; therefore, no additional payment is warranted.
98	Provider not contracted for the services rendered; therefore, your claim is denied.
99	Authorization for Mental Health services must be obtained prior to the seventh outpatient psychotherapy session; therefore, your claim is denied.
100	This statement is informational only and represents a posting to claims history of a previously issued manual payment.
101	Payment includes an additional allowance for blood clotting factor.
102	Insufficient diagnosis.
103	Non covered concurrent care.
104	Inpatient Nonavailability Statement authorization not on DEERS - contact the MTF.
105	Nonavailability Statement Authority no longer valid - Contact the MTF.
106	Services not covered under Cooperative Care Program

EOB Messages (Continued)	
107	Outpatient Nonavailability Statement not on DEERS; contact the military treatment facility for assistance.
108	Payment does not include professional service charges; bill separately on the HCFA 1500.
109	Incomplete DD Form 2527 received
110	Level of Care Billed Not Substantiated.
111	Services Denied Due To HMO Coverage or other primary health insurance
112	Preauthorization for this transplant not on file. Contact your contractor at the number listed on this Explanation of Benefits.
113	Does not meet criteria for pre-existing condition.
114	This service is part of a single group of services performed at the same time which *TRICARE* has paid. If this claim was filed on a participating basis, the beneficiary is not responsible for payment of the disallowed amount.
115	This amount plus the amount allowed on previous claim(s) for a part of this service performed at the same time is the maximum allowable amount for this service. If this claim was filed on a participating basis, the beneficiary is not responsible for payment of the disallowed amount.
116	Obsolete procedure code(s) submitted; future claims must contain current procedure code(s) or services will be denied.
117	Obsolete procedure code(s) submitted - service(s) denied; provider must provide correct procedure code(s).
118	No Nonavailability Statement for procedure or service performed.
119	These services require prepayment approval. Please call (insert telephone number) for assistance.
120	Provider is not TRICARE authorized. Requested provider certification information not received.
121	Other health insurance information not provided.
122	Consultation paid as limited office visit. Referring physician not identified.
123	Dental condition not a benefit. TRICARE coverage limited to authorized care required due to a medical condition.
124	Dental authorization not on file.

EOB Messages (Continued)	
125	Claim should be submitted to the CHAMPVA Center for processing. (See NOTE, Below.)
NOTE:	*EOB Message 125 listed above is an abbreviated version of the following message that the contractor shall use when the contractor denies a CHAMPVA claim when the DEERS response indicates a CHAMPVA alternate care flag "V". (See OPM Part Two, Chapter 1, Section IV.A.2.c.). In the absence of system limitations which preclude its use, the longer message must be used:* *"Claim denied as we are not responsible for processing CHAMPVA claims. Please resubmit the claim using VA Form 10-7959A and forward to: CHAMPVA Center, Post Office Box 65024, Denver, CO 80206-9024. Refer any outstanding questions to the CHAMPVA Center at 1-800-733-8387."*
126	Medical necessity for standby pediatric physician not documented.
127	Charge reimbursed at the intermediate office visit level.
128	Provider certification status not documented.
129	Checks not issued for amounts of $.99 or less.(See NOTE, Below.)
NOTE:	*Only applies to contracts awarded in FY 94 and thereafter.*
130	Amount allowed is based on a discount agreement.
131	Reserved
132	Partnership claim not correctly submitted.
133	Family member is no longer eligible, contact your nearest military personnel office or your Administering Secretary.
134	General office visit codes are not used for billing eye exam services. Please resubmit with appropriate codes.
135	Claims must be filed by the VA Medical Center.
136	Charge denied; this Durable Medical Equipment is available for loan from a local MTF.
137	Reserved
138	Services rendered by an unauthorized Marriage and Family Therapist. The provider should contact us for information on how to become a TRICARE authorized provider.

EOB Messages (Continued)	
139	Unauthorized Provider. Provider is either an active duty member of the Uniformed Services or a civilian employee of the U.S. Government and is prohibited by Regulation from billing TRICARE or TRICARE beneficiaries.
140	Services, supplies, and equipment associated with palliative care of terminal patient included within hospice all-inclusive rate.
141	Services curative in nature and waived as part of the beneficiary's election to receive care under TRICARE hospice benefit.
142	Claim denied due to hospice's failure to submit requested medical documentation within designated time frame (thirty (30) days from request).
143	Reclassification of hospice care to another rate category based on medical review.
144	Hospice reimbursement reduced to routine home care rate for inpatient respite care exceeding five (5) days.
145	Services paid under the ambulatory surgery prospective payment rates.
146	This claim is for a Medicare, not a TRICARE eligible beneficiary. No appeal rights are available. Please contact us if you have any questions.
147	Eligibility for Medicare pharmacy benefit not established. Contact DEERS Support Office (DSO) for assistance.
148	Payment reduced for failure to obtain preauthorization. The provider cannot bill for the difference.
149	Have you heard about TRICARE PRIME in Washington and Oregon? In the Prime Program there are no deductibles, no claim forms to file, low copayments, and more. FOR INFORMATION CALL 800-982-0032.
150	This claim has been reimbursed under a capitation agreement with the provider and does not reflect the actual payment for these services.
151	Authorization of cost sharing for the living-related donor liver transplant (LDRDLT) has been disallowed.
152	Your provider may bill you the lesser of its billed charge or 115 percent of the TRICARE allowable charge for each procedure listed on the claim and any noncovered service.

EOB Messages (Continued)	
153	The amount allowed has been reduced by ten (10) percent since the provider has refused to submit the claim or has charged an administrative fee for filing the claim. The ten (10) percent reductions and/or the provider's administrative fee are not billable to the beneficiary (patient), patient's sponsor or family, or representative, i.e., guardian or executor.
154	This claim processed without the required Primary Care Manager (PCM) or Health Care Finder (HCF) authorization. All future claims require authorization. To avoid paying at Point of Service (POS) rates, call your local TRICARE Service Center for assistance.
155	This claim cannot be processed without your PCM or HCF authorization. Please contact your local TRICARE Service Center for assistance.
156	Care not provided by network provider. Contact Lead Agent for assistance.
157	Claim does not meet criteria for interim payments. Bill must be submitted at sixty (60) day intervals.
158	*Claim for post-operative surgical component has been previously paid. Allowable amount has been reduced to the pre-intraoperative surgical component percentage.*
159	*Refill denied. Utilization levels have been reached.*
160	*Claims processed under Point of Service Option.*
161	*There was no accompanying documentation with the claim to justify payment of charges on fees exceeding the TRICARE allowed amount for the procedures.*
162	*The information submitted with this claim does not support an additional allowance.*
163	*Billed procedure codes rebundled into unbilled procedure code(s).*

e. Information Required on Reverse of EOB Form

All of the following information must be on the reverse of the EOB.

(1) Time Limit for Filing Claims

(a) For services provided before January 1, 1993, all claims submitted under TRICARE must be filed no later than December 31 of the calendar year immediately following the year in which the service or supply was provided.

FOR EXAMPLE:

For Service	File Claims By
January 1, 1992 - December 31, 1992	December 31, 1993

(b) For services provided on or after January 1, 1993, all claims submitted under TRICARE must be filed no later than one year after the date the service or supply was provided or one year from the date of discharge from an inpatient admission for facility charges only.

EXAMPLE:

For Service or Discharge	Received at the Contractor By
March 1, 1994	No later than March 1, 1995
December 31, 1994	No later than December 31, 1995

(c) If your claim was denied because it was not filed on time and you believe you were not at fault, contact us or your health benefits advisor for assistance. In limited circumstances, exceptions may be made. For example, the CHAMPUS Handbook (October 1994) has incorrect information regarding the timely filing of claims to the TRICARE contractors. The handbook states that claims "postmarked" within one year of the date the services was received are filed timely. The current TRICARE policy is the claim must be received by the contractor within one year of the date the service was provided. If more than one service is claimed, the filing deadline applies to the date each professional service was provided. Claims for nonprofessional institutional charges are to be submitted within one year of the date of an impatient's discharge. When a TRICARE contractor denies a service because it was not timely filed; however the person who submitted the claim states that he/she followed the instructions in the handbook, the Contractor is to accept the explanation given by the claimant and process the claim. Any claim with a service provided on a date that is beyond one year of the date stamped received by the contractor is to be denied. The contractor is to accept the postmarked date provided by person submitting the claim. It is not necessary for the contractor to verify the postmarked date.

(2) Sponsor, Patient, or Family Member Not Enrolled or not Eligible on DEERS

If the Defense Enrollment Eligibility Reporting System (DEERS) indicates that the sponsor, patient and/or family member is not enrolled or eligible for TRICARE benefits, you should contact your Health Benefits Advisor or your service personnel office. Claims will be denied if you are not enrolled in DEERS. If the claim was denied and the sponsor has recently gone on active duty, resubmit the claim with a copy of the duty orders and a photocopy of the patient's identification (ID) card (or parent's ID for family member under 10 years of age). If the sponsor is retired, resubmit the claim with the sponsor's retirement papers and a photocopy of the patient's ID card. If the sponsor is deceased, report to any service personnel office to get enrolled or call 800-538-9552 (in California, 800-334-4162; in Alaska or Hawaii, 800-527-5602).

(3) Identification Card (ID) or Eligibility Expired on DEERS

The Defense Enrollment Eligibility Reporting System (DEERS) indicates that the patient's ID card or eligibility has expired. To get a new ID card or extend eligibility, if sponsor is active duty, report at once to your parent service personnel office; if sponsor is retired or deceased, contact any service personnel office. If the claim was denied, when the patient obtains a current ID card, resubmit the claim with a photocopy of the new ID card. In an emergency, call 800-538-9552 (in California, 800-334-4162; in Alaska or Hawaii, 800-527-5602) for assistance.

NOTE:

Contractors may shorten messages (2) and (3) by eliminating the 800 numbers which do not apply to their region(s).

(4) Right to Appeal

If you disagree with the determination on your claim, you have the right to request a reconsideration. Your signed written request must state the specific matter with which you disagree and **MUST** be sent to the following address no later than ninety (90) days from the date of this notice. If the postmark on the envelope is not legible, then the date of receipt is deemed the date of filing. Include a copy of this notice. On receiving your request, all TRICARE claims for the entire course of treatment will be reviewed.

(Contractor's Address)

(5) TRICARE Outpatient Deductible

Effective for care provided on or after April 1, 1991, a TRICARE beneficiary is responsible for the payment of the first one-hundred-fifty dollars ($150.00) of the CHAMPUS-determined allowable costs or charges on processed claims for covered outpatient services or supplies provided in any one fiscal year. When outpatient services are provided to more than one beneficiary member of a family, the aggregate outpatient deductible amount paid by two or more beneficiary members of the family who submit claims shall not exceed three hundred dollars ($300.00) during any fiscal year. Deductible amounts remain unchanged for family members of active duty E-4s and below; $50.00 per beneficiary or $100.00 for two or more family members. Sponsors/beneficiaries are required to ensure that the proper pay grade/rank is on the DEERS records.

NOTE:

Additional information on the increased deductible is required through calendar year 1991; see Section I.F.4. *After CY 1991, the message above shall be used without additional information. If the contractor chooses to do so, it may revise the message above to include the additional information for calendar year 1991. The contractor may also use a stuffer along with the* EOB *message above to include the additional information; i.e., the specific categories of beneficiaries affected by the increase, deductible amounts paid to satisfy the current deductible will be applied to the increased deductible, and the deductible year remains unchanged although the deductible increase is effective in April.*

(6) If Payment not Based on the Full Amount Billed

The amount TRICARE may allow is limited by law to the lowest of:

(a) The *CHAMPUS* Maximum Allowable charge; which for most procedures is equal to the Medicare fee schedule amount; OR

(b) The amount the provider actually charges for the service or supply (to include a discounted charge that a participating provider has agreed to accept under a special program).

NOTE:

The above message may be used on and after May 1, 1992, for "flash" printed EOBs. The current stock of printed EOBs may be used until a new supply is required.

NOTE:

Under some circumstances, the contractor responsible for payment for care in the region will negotiate rates with preferred providers which will be different than the CHAMPUS Maximum Allowable Charge or the provider's usual charge. In such a case, the agreement made by the contracted provider, establishing allowable charge levels will prevail. In this instance, the provider will be participating and payment will be made directly to the provider who will be limited to the agreed charge level in full payment. Current stock of EOBs may be used until a new supply is printed with the new allowable charge description.

(7) Important Notices

(a) Always Give Your Social Security Number When Writing About Your Claim.

NOTE:

If inquiring about this claim, please provide the Internal Control Number located on the front of this form.

(b) You Can Use This Explanation Of Benefits:

1 As a deductible certificate to show your providers the amount of the outpatient deductible met as of the date of this notice.

2 As a record of bills paid or denied. (If you submitted other medical expenses not shown on this form, you will receive a separate notice.)

3 To collect other insurance. This notice may be used to claim benefits from a secondary insurance policy. Since the insurance company may keep this notice, it is advisable that you keep a record of this information.

(c) Claims payments are subject to the provision that the beneficiary cost-share is collected by the provider, whenever appropriate. The provider's failure to collect the cost-share can be considered a false claim and/or may result in reduction of payment.

(d) If you need more information:

1 Check your TRICARE *Standard* Handbook.

2 See the health benefits advisor or health care finder at the nearest Uniformed Services medical treatment facility.

3 Contact us at the address shown on the front of this form.

(e) Please review the services shown on the front side of the Explanation of Benefits (EOB). If you find that the payment consideration has been made for any services that you did not receive or that services were charged by a healthcare professional you did not see, please call the "800" telephone number on the front side of the EOB form.

4. Summary Voucher Information

The summary voucher must contain the following:

a. Form Title: "TRICARE/CHAMPUS Summary Payment Voucher"

b. Contractor's Name, Address, and Telephone Number.

c. Date of Notice.

d. Name, Complete Address including zip code, and identification number of payee.

e. Name of Beneficiary

f. Sponsor's Social Security number

g. Internal Control Number

h. Date of Service

i. Procedure Code and Brief Description of Service

j. Number of Services

k. Amount Billed

l. Amount Allowed

m. Denial code or reason for the denial. If codes are used, print the corresponding messages on the back of the form. (See Section VI.H.3., above, for acceptable messages.)

n. Deductible applied (the amount applied to the deductible).

o. Summary total to include billed charges, allowed charges, and amount to deductible or cost-share.

p. Total *TRICARE* payment made by this voucher to the payee.

q. Remarks (Enter longer explanation messages in this space.)

r. Other statements. (See Section VI.H.3.e.). The statements are not required on summary vouchers if a copy of the EOB is included with the voucher.

s. DRG Number

t. Amount paid by other health insurance

5. Explanations of Differences between Billed and Allowed Amounts

Each disallowance or reduction must be clearly explained on EOB's and summary vouchers using codes referring to statements on the reverse or using printed messages on the face. The messages used on the EOB must be compatible with those on the summary voucher.

6. Undeliverable EOB'S and Checks

EOB's, summary vouchers, and checks may be returned by the post office as undeliverable due to such reasons as:

a. Addressee Unknown

b. Incorrect Address

c. Moved, left no forwarding address

d. Addressee Deceased

e. Time Requirements for Research/Remailing

Contractors must accomplish all research for the correct address/addressee and remail within five (5) work days of the receipt of the returned mail. If address correction results in a remailing which is subsequently returned, the same procedures apply as for the first return.

f. Procedures for Handling Returned Beneficiary EOB's, Checks and Development Letters

(1) When a beneficiary's EOB, EOB and check, or development letter is returned as undeliverable due to addressee unknown, incorrect address, or moved, the contractor shall:

(a) Check the claim (hard copy or microcopy) to verify the accuracy of the addressee and address on the EOB or development letter and remail the original document with the correction if an error is found. (Correction of the address on file is also necessary if a discrepancy exists.)